



# Cape Regional Medical Center

**DIABETES AND HYPERTENSION CARE PROGRAM**

**LEARNING COLLABORATIVE- FEBRUARY 12, 2015**

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# Cape Regional Medical Center

- 242 Bed Acute Care Hospital
- 1,060 employees
- 111 active Medical Staff Members

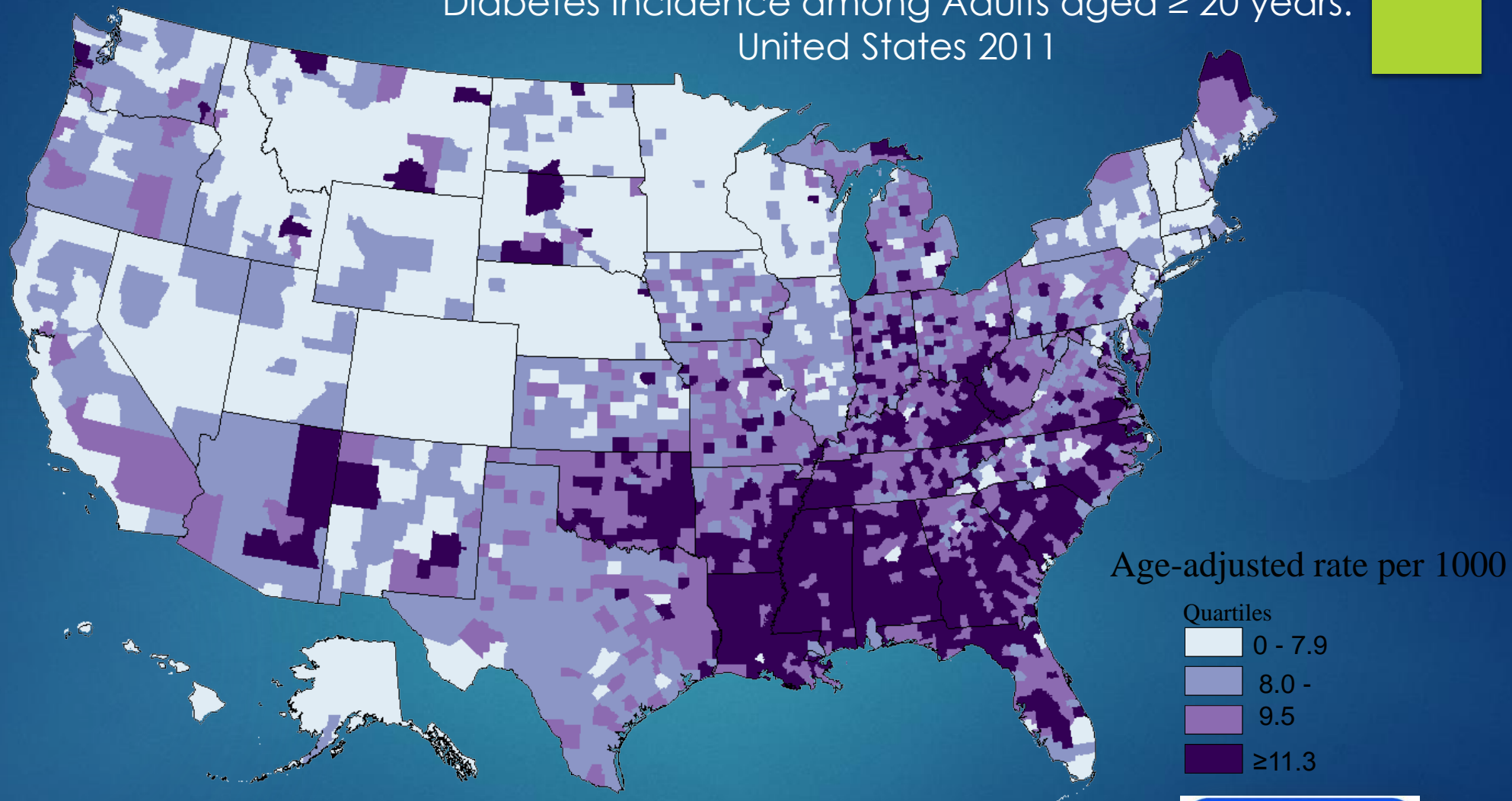


- Cape Regional Medical Center is the only hospital in Cape May County~ Southern NJ
- We serve an expanding local population and more than one million seasonal visitors with a variety of inpatient and outpatient services.
- Cape May County has a high retirement population rate.





Age-adjusted County-level Estimates of Diagnosed  
Diabetes Incidence among Adults aged  $\geq 20$  years:  
United States 2011



[www.cdc.gov/diabetes](http://www.cdc.gov/diabetes)





**Our mission** is to provide the highest quality healthcare to our community.

**Our vision** is to be the healthcare leader and provider of choice by developing a comprehensive, independent and high quality healthcare system

**We are fully accredited by the Joint Commission.**





## STRATEGIC PILLARS

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**GROWTH** : To increase inpatient and outpatient market share

**QUALITY** : To excel in the quality of services provided

**SERVICE** : To excel in customer service

**PEOPLE** : To become the workplace of choice

**FINANCE** : To excel in financial and operational performance



## Parish Nurse 2013 Community Needs Assessment

### High Importance in Diabetes and Hypertension

Many Community Screenings are done monthly by Parish Nursing and are referred to the Cape Regional Diabetes Center



# Cape Regional Diabetes Center

## Advanced Certification

Certified by The Joint Commission with the Gold Seal of Approval for its Advanced Inpatient Diabetes Program.

November 2011

December 2013

## ADA Outpatient Certification

2 Diabetes Outpatient sites are now offered in Cape May County

- Cape May Court House NJ
- Marmora NJ

Recent onsite Audit by the ADA

## DSRIP Program New Jersey

“ For New Jersey to be a state which people live long healthy lives”

Healthy New Jersey 2020



# 2013 & 2014 Intracycle Project

## Long Term Facilities Throughout the County

- Weight Based Insulin Protocol
- Carb Counting
- NO Sliding Scale
- Standard Hypoglycemia Protocols
- Long Term Facility Champions- Diabetes Educators, CDE's & RD will visit onsite for follow up educational programs

## Cape Regional Medical Center : striving to design programs and services that have a impact on the communities we serve.

- Community Based Activities- Home and Health Show
- Education & Support Group Classes
- Community Walks at Our County Park & Zoo
- Grocery Store Visits with RD/CDE" Look/Learn/Label Reading"

The Incentive Gained from the DSRIP program for our community will be one more way to enhance Diabetes and Hypertension Care in our hospital and throughout the county.



## **DSRIP Program Development & Progress**

A standardized documentation tool based on the 2014 ADA standards was developed for our reporting partners Cape Regional Physician Association To identify and track patient risks of complications and referred to the Diabetes Center for Diabetes Self Management Education and Training.

Pilot Program was at one Cape Regional Physician Association Office. Continue to work with IT to pull data and evaluate.

Emergency Room Daily Report Developed and faxed to Diabetes Center that identify discharged patients with Diabetes and Hypertension.

Diabetes Discharge Care Plan that gives patients follow up appointment with PCP even if discharged to long term facility. Updated HGB A1C results are also listed on discharge instructions and transfer sheet.

Transitional Care Nurse that works with patient and PCP office to identify level of care needed for F/U appointment.





## Abstraction Tool- Welcomed !

NJ-HITEC helps by offering hospitals with DSRIP support in:

- **Identification** of beneficiary population via claims and diagnosis
- **Collection** of numerators and denominators with NJ-HITEC tools
- **Reporting** all Stage 3 and Stage 4 measures to NJ Medicaid



**Van Ly**  
**Workflow Manager**

# Brainstorming Challenges

## A Team Effort

DSRIP TEAM

Administration

Medical Staff

Information Technology Team

Cape Regional Physician Offices-Reportable Partner

Care Management

SJ DSRIP Collaborative

Transitional Care Nurse

Extended Partners~ Parish Nursing, Crest Haven

Nursing & Rehabilitation, VIM

Identification	<ul style="list-style-type: none"> <li>•Daily Hb A1C result report (report includes all results for inpatient and outpatient ) prints to Care Management Department at 0600.</li> <li>•Past episodes of care, medical history and current review of systems iare reviewed in transcribed H&amp;P's for documentation of diabetes and hypertension.</li> <li>•Care Management Transition Coordinaton Assistant reviews criteria.</li> <li>•Patient's discharged on weekend will be identified on Monday.</li> </ul>
Notification	<ul style="list-style-type: none"> <li>•Care Management Transition Coordination Assistant enters criteria into Managed Care Patient section in Allscripts Care Management Suite for current inpatients.</li> <li>•Criteria entered into Managed Care Patient will populate every time a patient has a hosptialization.</li> <li>•This notification triggers Care Management staff to initiate initial care coordination assessment.</li> </ul>
Assessment	<ul style="list-style-type: none"> <li>•Nurse Care Manager identifies Managed Care Diagnosis</li> <li>•Nurse Care Manager interviews patient using Disease Specific Assessment: Diabetes</li> <li>•Refer to Exhibit A</li> </ul>
Coordination Based on Initial Assessment Response	<ul style="list-style-type: none"> <li>•If patient's primary care provider is Cape Regional Physician Associate(CRPA), patient will meet with CRPA Transition Nurse prior to discharge.</li> <li>•CRPA Transition Nurse will arrange for follow-up appointment and document coordination in clincial record.</li> <li>•Transition Coordination Assistant will enter appointment on discharge instructions.</li> <li>•If patient states has prescheduled follow-up appointment with physician, documentation of follow-up appointment will be entered into clincial record.</li> <li>•If patient has no primary care provider, insurance or homeless ness an appointment will be arranged at Complete Care, Volunteers in Medicine or Cape Regional Diabetic Center</li> </ul>
Communication	<ul style="list-style-type: none"> <li>•Discharge Home/VNA</li> <li>•Follow-up physician appointment will be entered on electronic discharge instruction by Care Management Transition Cooordination Assistant</li> <li>•Discharge with Post Acute Care Facilities</li> <li>•Hand-off care recommendations for physician appointment will be entered on electronic discharge instruction by Care Management Transition Cooordination AssistantWeekend diischarges will be contacted at home or skilled nursing facility will be notified.</li> </ul>
Evaluation	<ul style="list-style-type: none"> <li>•Transition Coordinator Assistant will log all arranged appointments.</li> <li>•Follow-up call to physician's office post appointment to verify compliance with follow-up visit.</li> <li>•Monthly audit of scheduled compliance with appointment.</li> </ul>

**Appointment  
For PCP/DE  
Made Prior to  
Discharge**





# Recognition News

## Program Spotlight

In this December issue, we focus our spotlight on Cape Regional Medical Center (CRMC), a community hospital in the southernmost part of the State of New Jersey. The hospital is the only one in Cape May County. CRMC boasts a strong dedication to prevention; early detection and treatment of diabetes .



Row 1 (left to right): Cindy Kraemer BSN, CDE, PRNR, Beth Polvino RN-BC, Patti Birchall BSN, CDE, Kathleen Young BSN, CDE, Margaret Monge RD, CDE, Flo Smith Secretarial Coordinator, Doreen Fitzpatrick DNP, APN, BC,

Back Row (left to right): Richard Artymowicz PharmD, FCCP, BCPS, Lauren McCarthy PharmD, BCPS, Fred Schuster, MA, STS, Dr. Christopher Zitnay MD, MS, Barbara Moore Laboratory Director, Dr. Arthur Childs DO, Jaqueline McCabe RN